

Amount Received \$ _____	For DASA use only	Date Received _____	Log #: _____
Check No. _____ Application No: _____	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div>		

APPLICATION FOR CERTIFICATION OF A BRANCH OF A CERTIFIED CHEMICAL DEPENDENCY SERVICE PROVIDER

Division of Alcohol and Substance Abuse (DASA)
Department of Social and Health Services (DSHS)
Olympia, Washington

Please complete **PARTS 1 through 7** of the application form, return the form with the required information/materials and the \$500 application fee.

PART 1 – MAIN AGENCY INFORMATION (See instructions at back of application)

1. Name of Main Agency
2. Agency Number for Main Agency
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PART 2 – BRANCH AGENCY INFORMATION (See instructions at back of application)

1. Name of Branch Agency (See instructions)			
2. Additional Organizational Title (See instructions)			
3. Branch Street Address	City	State	Zip Code
3a. <input type="checkbox"/> Branch street address to be submitted at a later date			
4. Branch Mailing Address (if different from street address)			
City State Zip Code			
4a. <input type="checkbox"/> Temporary application mailing address only; mailing address will be submitted at a later date, or,			
4b. <input type="checkbox"/> To be branch agency mailing address at time of certification			
5. Telephone Number (Include area code) () _____ () _____ 5a. <input type="checkbox"/> Temporary application contact telephone number only, and branch agency telephone number will be submitted at a later date. or, 5b. <input type="checkbox"/> To be branch agency telephone number at the time of certification.	6. Fax Number (Include area code) () _____ 6a. <input type="checkbox"/> Temporary application fax number only, and branch agency fax number will be submitted at a later date or, 6b. <input type="checkbox"/> To be branch agency fax number at time of certification		

7. TDD Number (Include area code) (optional) () _____ 7a. <input type="checkbox"/> Branch TDD number to be submitted at a later date	8. E-Mail Address (optional) _____ @ _____ 8a. <input type="checkbox"/> Temporary application e-mail address only, and branch agency e-mail address will be submitted at a later date; or, 8b. <input type="checkbox"/> To be branch agency e-mail address at time of certification
9. On-site Branch Administrator's Name _____ 9a. <input type="checkbox"/> Name will be submitted at a later date	9b. Title
10. Branch Clinical Supervisor's Name _____ 10a. <input type="checkbox"/> Name will be submitted at a later date	10b. Title

PART 3 – PROVIDER INFORMATION (See instructions at back of application)

All providers:

11. Federal Employer Tax Identification Number (FEIN) (May use Social Security Number (SSN) if Sole Proprietor):

<input type="checkbox"/> FEIN <input type="checkbox"/> SSN	
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Privately owned providers only:

12. Washington State Uniform Business Identification Number:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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PART 4 – CHEMICAL DEPENDENCY SERVICES (See instructions at back of application)

13. DETOX AND RESIDENTIAL SERVICES	TOTAL # OF BEDS	SPECIAL TREATMENT FOCUS
<input type="checkbox"/> Detoxification - Acute		
<input type="checkbox"/> Detoxification - Subacute		
<input type="checkbox"/> Intensive Inpatient		
<input type="checkbox"/> Recovery House		
<input type="checkbox"/> Long-Term Treatment		

14. NON-RESIDENTIAL SERVICES	ESTIMATED # OF PERSONS TO BE SERVED ANNUALLY	SPECIAL TREATMENT FOCUS
<input type="checkbox"/> Outpatient		
<input type="checkbox"/> Intensive Outpatient		
<input type="checkbox"/> DUI Client Assessment		
<input type="checkbox"/> Alcohol/Drug Information School		
<input type="checkbox"/> Opiate Substitution Treatment		
<input type="checkbox"/> Treatment Alternatives to Street Crime (TASC)		
<input type="checkbox"/> Free-Standing ADATSA Assessments		
<input type="checkbox"/> Outpatient Childcare		
<input type="checkbox"/> Information and Crisis Services		
<input type="checkbox"/> Emergency Service Patrol		

PART 5 - CONTRACTS

15. Does your agency now receive government funds, or does your agency intend to provide chemical dependency treatment services at the branch site for which you will receive government funds?
☐ Yes ☐ No
16. If yes, indicate the source(s), e.g., federal, state, tribal, county, criminal justice, corrections, or other:

17. Please identify the certified chemical dependency treatment service(s) for which contract funds are or may be provided at the branch site:

PART 6 – MATERIALS TO BE SUBMITTED WITH THE APPLICATION (See instructions)

- A. For the on-site branch agency administrator designated by the governing body, a copy of the report of findings from a criminal background check, as conducted by the Washington State Patrol and the last state of residence if the person has lived outside of Washington State within the past three years.
- B. **If planning to offer detoxification or residential services**, a copy of the Residential Treatment Facility or Hospital license issued by the Washington State Department of Health (DOH), Facilities and Services Licensing Division; or in cases of nursing home facilities, the license from the Washington State Department of Social and Health Services (DSHS).
B1. ☐ License enclosed B2. ☐ To follow at a later date B3. ☐ Not applicable
- C. Evidence of sufficient qualified staff to deliver the chemical dependency services at the site applied for that includes:
1. A copy of an organizational chart showing each staff position, including volunteers, students, and persons on contract, by job title, lines of responsibility, the full-time equivalency percentage for each position, and how the agency relates to any parent organization.
 2. A copy of the job description for the on-site branch administrator and each staff person who will be providing or supervising patient care.

3. A copy of the current certificate of certification as a Chemical Dependency Professional issued by the Washington State DOH for each chemical dependency professional to be employed by your organization at the proposed branch site.

3a. ☐ Certificate(s) Enclosed

3b. ☐ To follow at a later date

Note: The wall certificate issued by DOH is not sufficient. The certificate must include the certification expiration date.

4. **If applying as a municipal or district court probation office**, submit evidence of the employment of a probation assessment officer that meets the requirements of WAC 388-805-220.

4a. ☐ Evidence Enclosed

4b. ☐ To follow at a later date

5. **If applying for certification to provide alcohol/drug information school services at the branch site**, then submit evidence of the employment of a qualified alcohol/drug information school instructor that meets the requirements of WAC 388-805-250.

5a. ☐ Evidence Enclosed

5b. ☐ To follow at a later date

D. Branch facility information as follows:

1. A completed Americans with Disabilities Act (ADA) Checklist for Existing Facilities.
2. A plan of the premises, which show that the chemical dependency treatment services are discrete from other programs, and indicates the capacities of buildings for its intended uses.
3. A floor plan showing the use of each room and the location of specific facility details as listed in WAC 388-805-015(2)(l)(i-vii).

3a. ☐ Facility information enclosed

3b. ☐ To follow at a later date

- E. **If applying for outpatient child care certification at the branch site**, and the agency is licensed by the Department of Social and Health Services Division of Children and Family Services (DCFS), provide a copy of the current license. *If the child care service is not currently licensed*, but the organization intends to apply to DSHS later, please indicate below. *If the organization is seeking DASA certification*, then submit evidence of meeting the requirements of WAC 388-805-900 through 935.

☐ DSHS DCFS License enclosed

☐ To follow at a later date

- F. **If your agency is accredited by a DASA recognized national chemical dependency accreditation body**, submit a copy of the letter notifying the accreditation body of this application to provide services at a new site.

Note: Your agency will not be eligible for deemed status under WAC 388-805-115 until your branch agency has been granted standard certification.

- G. **An application fee of \$500** must be submitted with this application, and must be in the form of a check or money order made out to the Department of Social and Health Services.
- H. A copy of the cover letter used to notify the county alcohol/drug coordinator for the county where branch services will be provided of this application.

PART 7 – DECLARATIONS (See instructions at back of application)

I will notify DASA if changes occur in any of the information provided in Parts 1 through 6 of this application before certification occurs.

I declare that I have read the privacy notice on page 6 of this application.

I declare that no person named in this application has had a license or certification for a chemical dependency treatment service or health care agency denied, revoked, or suspended, as referenced in WAC 388-805-065(1)(a).

I declare that no person named in this application has been convicted of child abuse or adjudicated as a perpetrator of substantiated child abuse, as referenced in WAC 388-805-065(1)(b).

I declare that no person named in this application has obtained or attempted to obtain a health provider license, certification, or registration by fraudulent means or misrepresentation, as referenced in WAC 388-805-065(1)(c).

I declare that no person named in this application is currently under investigation for having committed, permitted, aided or abetted the commission of an illegal act or unprofessional conduct as defined under Chapter 18.130.180 RCW, as referenced in WAC 388-805-065(1)(d).

I declare, as required by WAC 388-805-020(2)(b), that a copy of the agency policy and procedure manual will be maintained at the branch site and that the manual has been revised to accommodate the differences in business and clinical practices at the branch site.

I declare that the information contained in this application and on all documents submitted with this application is true, accurate, and complete to the best of my knowledge.

Signature of on-site administrator or other responsible party	Date
Address	Telephone ()
Type or Print Name	Title

Return the original application form, one copy of the items required in **PART 6**, and the nonrefundable \$500 application fee to the attention of:

Robert Geissinger, CCDCIII, Certification Specialist
Certification Section
Department of Social and Health Services
Division of Alcohol and Substance Abuse
Post Office Box 45330 (Mail Stop 45330)
Olympia, Washington 98504-5330

Privacy Notice

This notice is provided in compliance with Governor's Executive Order 00-03 and addresses the collection, use, security, and access to information obtained by your submission of this application or request.

DASA requires an applicant who is applying for certification to provide chemical dependency services as a sole proprietor to submit a Federal Employer Tax Identification Number or their personal Social Security Number. The number is used to identify a specific person or legal entity that owns a specific business.

DASA also requires an applicant to submit the name, address, and telephone number for each owner of 5% or more of the organizational assets. Additionally, we require owners and the administrator to submit copies of the results of a criminal background check conducted by the Washington State Patrol. This information will be used to determine whether a specific person is a qualified applicant under WAC 388-805-065.

Applicants may decide to provide personal contact information (address, or telephone number) in lieu of business contact information. Addresses and telephone numbers identified as personal information and criminal background checks may be disclosed to parties outside of the department without written consent of the involved party.

All information collected as a part of the application or a request for departmental approval is collected for considering applicant and provider compliance with applicable regulations related to their requests. All information is considered public information, and may be made available to anyone submitting a proper public information request unless exempted by the Public Information Disclosure Act under Revised Code of Washington 42.17.310(1).

Information may be retained for the period of provider certification to include any subsequent changes in provider ownership. The department will retain records for up to six years following the voluntarily cancellation of certification, and indefinitely in cases of involuntary cancellation, revocation, or suspension of certification. Information will be destroyed after that time.

Persons submitting information have the right to review personal information on file with the department. You can recommend changes to your personally identifiable information you believe to be inaccurate by submitting a written request that credibly shows the inaccuracy. We will take reasonable steps to verify your identity before granting access or making corrections.

Please contact Bob Geissinger if you have any questions or concerns. Contact information is provided with this application.

Note: You do not have to return the instructions with your application. Program manuals will be returned to the applicant after they are reviewed.